STATE OF MICHIGAN

IN THE SUPREME COURT

COVENANT MEDICAL CENTER,

Plaintiff/Appellee,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, a Michigan insurance corporation,

Defendant/Appellant.

/

Supreme Court No. _____

Court Of Appeals Docket No. 322108

Saginaw County Circuit Court
Case No. 13-020416-NF

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DEFENDANT-APPELLANT STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY'S APPLICATION FOR LEAVE TO APPEAL

ORAL ARGUMENT REQUESTED

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On October 22, 2015, the Court of Appeals, in a published opinion, reversed the Saginaw County Circuit Court's grant of summary disposition in favor of Defendant-Appellant State Farm Mutual Automobile Insurance Company ("State Farm"). (The Court of Appeals' opinion is attached as Exhibit A and the Circuit Court opinion is attached as Exhibit B.) This Application for Leave to Appeal is filed on December 3, 2015, and is therefore timely submitted pursuant to MCR 7.305(C)(2). For the reasons stated herein, State Farm requests that this Court grant this Application for Leave to Appeal and reverse the Court of Appeals.

STATEMENT OF QUESTION PRESENTED FOR REVIEW

The Court of Appeals, in a published decision, reversed the Circuit Court's grant of summary judgment to State Farm, and held that a settlement and release between an insured and State Farm, his No-Fault insurer, over personal protection insurance ("PIP") benefits, including all medical bills, did not bar a subsequent suit by the insured's health care provider, Covenant Medical Center ("Covenant"), for payment of medical bills, because State Farm had prior written notice of Covenant's claim (in the form of bills sent to State Farm by Covenant), and therefore State Farm was required to ask the Circuit Court for an order apportioning the benefits.

Should this Court grant leave to appeal and on appeal, reverse, where:

a. the Court of Appeals' decision involves legal principles of major significance to the state's jurisprudence because it involves the rights of insurers, insureds, and medical providers; will cause significant delay in the payment of PIP benefits; and will increase litigation and court proceedings, burdening the judicial system;

b. the Court of Appeals' decision is clearly erroneous and will cause material injustice because it misinterprets MCL 500.3112 as making an apportionment proceeding the only way an insurer may discharge its liability to pay benefits rather than just one way; does not acknowledge that written notification under Section 3112 is only relevant to the question of whether an insurer that paid a claim for benefits in good faith is statutorily discharged of liability, and is not dispositive of whether the insurer's liability is terminated by a release; turns the option of seeking an apportionment order into a requirement; and assumes a provider is "some other person" when the provider's claims are derivative of those of the insured; and

c. the Court of Appeals' decision conflicts with other decisions of the Court of Appeals holding that provider's claims are derivative of, and identical to, those of the insured and providers "stand in the shoes of" the insured?

Defendant-Appellant State Farm answers:	"Yes"
Plaintiff-Appellee Covenant Medical Center would answer:	"No"
The Circuit Court would answer:	"Yes"
The Court of Appeals would answer:	"No"
This Court should answer:	"Yes"

INTRODUCTION

This case involves the proper interpretation and application of Section 3112 (MCL 500.3112) of Michigan's No-Fault Insurance Act, MCL 500.3101, *et seq.* (the "No-Fault Act"). State Farm's insured, Jack Stockford, filed suit against State Farm seeking personal protection insurance ("PIP") benefits following an auto accident. That dispute was settled with a payment to Mr. Stockford by State Farm and Mr. Stockford's execution of a release, which released State Farm from all claims and damages incurred as a result of the accident, including (but not limited to) medical expenses (the "Release"). The Release contained a provision in which Mr. Stockford agreed to indemnify and hold State Farm harmless from any liens or demands made by any of his heath care providers, including Plaintiff-Appellee Covenant Medical Center ("Covenant"), which had earlier sent bills to State Farm for services provided to Mr. Stockford. The Release also expressly stated that it was the intention of the parties that State Farm have no further liability for any claims related, directly or indirectly, to Mr. Stockford's accident.

After the Release was executed, Covenant filed suit against State Farm seeking payment of its medical bills related to the accident. State Farm moved for summary disposition based on the Release. The Circuit Court granted State Farm's motion, holding PIP benefits are not payable for the benefit of an insured under Section 3112 if the insured has signed a release and settled his or her claims with the insurer. The Court of Appeals reversed in a published decision, holding the Release did not discharge State Farm's liability to Covenant because State Farm had prior written notice of Covenant's claim. The Court of Appeals further held that Section 3112 required State Farm to apply to the Circuit Court for an order directing how the PIP benefits should be apportioned.

The Court of Appeals' opinion involves legal principles of major significance to the state's jurisprudence. To say that this decision has turned the current no-fault system on its head

and caused consternation to the entire industry is not an overstatement, as its effect is to virtually eliminate the possibility of timely out-of-court settlements for PIP claims. The opinion affects: (1) the rights of insurance companies, insureds, and providers; (2) the judicial system, which will be overburdened by (a) new suits filed to apportion payments of PIP benefits (where there was no litigation pending before a settlement was reached), and (b) motions for same (where there was already litigation over the claim, but which will increase litigation costs and further delay the proceedings), (3) the body of no-fault case law, which has become inconsistent, and (4) the goals of the No-Fault Act, which are thwarted because benefits will no longer be promptly payable to insureds with minimal costs and burden on the judicial system.

The Court of Appeals' decision is also clearly erroneous and will cause material injustice. The Court of Appeals misinterpreted MCL 500.3112 by making an apportionment proceeding the only route by which an insurer may discharge its liability with any certainty. The statutory language is discretionary, providing that an application for apportionment "may" be filed. But the Court of Appeals held such an application is mandatory and the only way in which an insurer's liability can be discharged with any certainty when the insurer is aware of the "claim of some other person." While the plain language of Section 3112 provides one "safe harbor" method of discharge, it certainly is not the only way by which an insurer may discharge its liabilities.

In reality, no-fault disputes are most often resolved by way of settlement agreement and release, which this Court has recognized as essential to the no-fault system, and not by a Section 3112 apportionment order. But that will no longer be the case, due to the Court of Appeals' holding that any time an insurer is given written "notice" of an injured-party-dependent claim by a "third" party (which occurs in nearly every case if medical bills are considered sufficient

notification for Section 3112 purposes), that insurer must apply to the Circuit Court for Section 3112 apportionment before making payments or otherwise be subject to potentially having to pay the same claims twice.

An apportionment order may not, however, end the litigation. The Court of Appeals' decision necessarily assumes, without so holding, that the Circuit Court has jurisdiction to bind all providers, irrespective of whether there are other lawsuits pending in other venues regarding the same benefits. Often, the injured insured files suit against their insurer in one court (usually Circuit Court) seeking payment of PIP benefits, including medical bills; and his or her medical provider(s) bring their own lawsuit(s) in different courts (often in district court), seeking payment of those same medical bills. Under the Court of Appeals' opinion, to resolve the primary case brought by the insured, the insurer must ask the Circuit Court to make an apportionment of the benefits. Yet the providers who have brought their own suits in different venues will likely claim the Circuit Court lacks jurisdiction to bind them as they have their own lawsuits pending in other courts. Thus, questions regarding the Circuit Court's powers under Section 3112 will likely spawn additional litigation.

Similarly, an insurer participating in the mandatory case evaluation process must now choose between two unfavorable options – 1) accepting an award, knowing it may still face assertions by others that the award does not resolve their claims as they were not parties to the litigation (indeed, most claimants present numerous medical bills at the case evaluation thus putting the insurer on "notice" of claims by non-parties to the case), and 2) rejecting an award for this very reason and therefore facing potential case evaluation sanctions. The Court of Appeals' decision opens a Pandora's box of problems.

The Court of Appeals also erred in not acknowledging that written notice under Section

3112 is only relevant to the question of whether an insurer that paid a claim for benefits in good faith is *statutorily* discharged of liability under Section 3112. It is not relevant to, let alone dispositive of, whether the insurer's liability is terminated by a release. And the Court of Appeals erred in assuming that the claim of a provider is a claim of "some other person" under Section 3112, when, under Court of Appeals' precedent, the claims of a provider are derivative of the claims of the insured and the provider therefore "stands in the shoes of" the insured.

Furthermore, the Court of Appeals' decision conflicts with other decisions of that court. The opinion seemingly grants providers (and perhaps other "persons" as well) a separate and independent right to recover PIP benefits that is unrelated to, and unaffected by the actions of, the insured. Such a holding is inconsistent with the case law holding that PIP benefits belong to the injured person; and that providers and others similarly situated have derivative claims.

The consequences of the Court of Appeals' erroneous decision are very real. Insurers now cannot be sure that their liabilities are discharged without going to court. Claims that were typically settled without court involvement will now require apportionment proceedings, in which insureds and providers will be forced to participate even if there was no dispute regarding the benefits owed or the amount to be paid. Indeed, under the Court of Appeals' decision, apportionment proceedings will be required on every claim, whether it is resolved by pre- or post-litigation settlement agreement, case evaluation, or jury verdict. All of these scenarios will result in delayed payment to injured persons, increases in litigation costs, and further stresses on an already overburdened judicial system. Leave to appeal should be granted under MCR 7.305(B)(3) and (5).

STATEMENT OF MATERIAL PROCEEDINGS AND FACTS

I. THE NO-FAULT ACT AND SECTION 3112

The No-Fault Act, which became law on October 1, 1973, was created to eradicate

problems inherent in the liability system involving auto accidents, including long payment delays, high legal costs, and overburdened courts. *See Shavers v Attorney General*, 402 Mich 554, 578-579; 267 NW2d 72 (1978). The goal of the no-fault insurance system was – and is – to provide victims of motor vehicle accidents with "assured, adequate, and prompt reparation for certain economic losses." *Cruz v State Farm Mut Auto Ins Co*, 466 Mich 588, 595; 648 NW2d 591 (2002). The Legislature believed this goal could be most effectively achieved through a system of compulsory insurance, under which every Michigan motorist is required to purchase no-fault insurance or be unable to operate a vehicle legally in this state. Under this system, victims of motor vehicle accidents receive insurance benefits for their injuries as a substitute for their common-law remedy in tort. *Id.* "The act [wa]s designed to minimize administrative delays and factual disputes that would interfere with achievement of the goal of expeditious compensation of damages suffered in motor vehicle accidents[,]" *Miller v State Farm Mut Auto Ins Co*, 410 Mich 538, 568; 302 NW2d 537 (1981), and the "ability of insurers to settle claims is essential to meeting these goals." *US Fid Ins & Guar Co v Mich Catastrophic Claims Ass'n* ("*USF&G*"), 484 Mich 1, 25; 795 NW2d 101 (2009).

Section 3112 of the No-Fault Act states:

> Personal protection insurance benefits are payable to or for the benefit of an injured person or, in case of his death, to or for the benefit of his dependents. Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person. If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person may apply to the circuit court for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and

> other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay:
>
> (a) To the dependents of the injured person, the personal protection insurance benefits accrued before his death without appointment of an administrator or executor.
>
> (b) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse.

This provision provides: (1) to whom PIP benefits may be paid, and (2) a "'safe' method of payment of benefits by insurers." *Miller v State Farm Auto Ins Co,* 410 Mich 538, 568; 302 NW2d 537 (1981). As to the former, when the injured person is living, PIP benefits may be paid to the injured person OR for the benefit of an injured person. MCL 500.3112. If the injured person is deceased, then the benefits may be paid to the injured person's dependents OR for the benefit of the injured person's dependents. *Id.*

II. THE CURRENT DISPUTE

A. Mr. Stockford's Accident; Release with State Farm; and The Circuit Court's Decision

Jack Stockford was injured in a motor vehicle accident on June 20, 2011. (Complaint, attached as Ex. C, ¶ 5.) At the time of the accident, Mr. Stockford had automobile insurance through State Farm. Covenant provided medical services for Mr. Stockford's injuries arising from the accident on various dates through October 3, 2012. (*Id.*, ¶ 8.) Covenant billed State Farm in 2012 for the services rendered, but State Farm did not pay the bills. (*Id.*, ¶¶ 11, 14.)

Mr. Stockford filed suit against State Farm on June 4, 2012 in Saginaw County Circuit Court for PIP benefits related to the accident. On April 2, 2013, Mr. Stockford entered into a release with State Farm. (Release Regarding Claim for Personal Protection Insurance Benefits Under Michigan No-Fault Automobile Act ("Release"), attached hereto as Exhibit D). State Farm agreed to pay Mr. Stockford $59,000 and the Release was a full

and final release of State Farm "regarding all past and present claims incurred through January 10, 2013 for what are commonly referred to as first party benefits or personal injury protection benefits under the Michigan No-Fault Automobile Insurance law, arising from the June 20, 2011 accident...." (Exhibit D, p. 1.) Mr. Stockford specifically agreed that the Release was a "complete release of [State Farm] regarding any and all past and present claims incurred through January 10, 2013, under the Michigan No-Fault Act the undersigned may have...including but not limited to allowable expenses, medical bills,...arising from the June 20, 2011 accident...." (*Id.*, pp. 1-2). Mr. Stockman agreed to indemnify and hold State Farm harmless from "any liens or demands made by any provider," including, but not limited to, Blue Cross/Blue Shield, "Saginaw Covenant Medical Center", and others for services rendered to Mr. Stockford in connection with any injuries resulting from the accident. (*Id.*, p. 3.) The Release concluded:

> It is the express intention of the parties to this settlement that this Release be read as broadly as possible such that [State Farm] shall have no further obligations or liability of any sort or nature to Jack H. Stockford, directly or indirectly, except as stated in this Release. The parties agree that the settlement payment referenced above is given as compensation in full satisfaction for any and all claims for no-fault benefits incurred through January 10, 2013, and for past, present and future wage loss claims under the Michigan Automobile No-Fault Act, and including but not limited to, attorney fees, costs and expenses.

(*Id.*, pp. 3-4.)

Covenant filed its Complaint in this matter on April 25, 2013 in Kent County Circuit Court (later transferred to Saginaw County Circuit Court) against State Farm, alleging that State Farm was required to reimburse Covenant for medical services rendered to Mr. Stockford because of the June 20, 2011 automobile accident. (Exhibit C.) State Farm filed a Motion for Summary Disposition pursuant to MCR 2.116(C)(7) and (C)(8). The Circuit Court

granted State Farm's motion on May 15, 2014, finding the Release to be dispositive. (Circuit Court Opinion and Order, Exhibit B.)

Specifically, the Circuit Court held that "[n]otwithstanding any argument as to a medical provider's ability to pursue a direct action on a claim for the payment of no-fault benefits owed by an insurer, **such an action remains dependent on the insurer being obligated to pay benefits to the provider on behalf of the insured**." (Exhibit B, p. 4) (emphasis added). The court, relying on the plain language of MCL 500.3112, found that any right a provider may enjoy under Section 3112 "flows solely from the fact that the provider is seeking benefits 'payable . . . for the benefit of any injured person . . . .'" (Exhibit B, p. 4, quoting Section 3112.) In other words:

> No insurance benefits remain payable to or for the benefit of an insured under § 3112 when the claims have been settled by the insured and a valid release executed. That release ends the insurer's obligation to pay benefits to or on behalf of its insured under its contract of insurance.

(Exhibit B, p. 4.)

The Circuit Court relied on *Michigan Head & Spine Institute, PC v State Farm Mut Auto Ins Co,* 299 Mich App 442; 830 NW2d 781 (2013), in which the Court of Appeals found that a release signed by the insured discharged an insurer's liability to a provider. The Circuit Court found that the fact that the notice of the provider's claim in that case was provided to the insurer after the release was signed was irrelevant because the "insurer's liability . . . was terminated by the release not by statute." (Exhibit B, p. 5.) The Circuit Court also relied on the holding in *Moody v Home Owners Ins Co*, 304 Mich App 415; 849 NW2d 31 (2014), that providers' claims against an insurer "are completely derivative of and dependent on [the insured] having a valid claim of no-fault benefits against defendant." (Exhibit B, p. 6, quoting *Moody*). The court also quoted *Moody's* holding that "the injured party may waive by agreement his or her claim

against an insurer for no fault benefits, and a service provider is bound by the waiver" and "a service provider's remedy is to seek payment from the injured person." (*Id.*) The Circuit Court granted State Farm's Motion for Summary Disposition pursuant to MCR 2.116(C)(7) and Covenant appealed.

B. The Court of Appeals' Decision

The Court of Appeals reversed, holding that "because [Covenant] provided written notice to State Farm regarding the medical services provided to Stockford, [Covenant] is entitled" to pursue its claim for medical bills, penalties, interests and costs. (Exhibit A, p. 2.) The Court of Appeals interpreted Section 3112 as follows:

> MCL 500.3112 provides that if the insurer does not have notice in writing of any other claims to payment for a particular covered service, then a good faith payment to its insured is a discharge of its liability for that service. However, the plain text of the statute provides that if the insurer has notice in writing of a third party's claim, then the insurer cannot discharge its liability to the third party simply by settling with its insured. Such a payment is not in good faith because the insurer is aware of a third party's right and seeks to extinguish it without providing notice to the affected third party. Instead, the statute requires that the insurer apply to the circuit court for an appropriate order directing how the no-fault benefits should be allocated. That was not done in this case. Accordingly, pursuant to the plain language of the statute, because State Farm had notice in writing of Covenant Medical's claim, State Farm's payment to Stockford did not discharge its liability to Covenant Medical.

(*Id.*, pp. 2-3.) The Court of Appeals found *Mich Head & Spine* to be inapplicable because State Farm had notice of Covenant's claim before it settled with Mr. Stockman. The Court of Appeals held "where the relevant services were rendered and the insured received notice of the provider's claim *before* the settlement occurred, the payment and release does not extinguish the provider's rights." (Ex. A, p. 3, emphasis in original.)[1] As for *Moody*, the Court of Appeals held, "while a

[1] The Court of Appeals did not state how it believed State Farm received written notice of

provider's right to payment from the insurer is created by the right of the insured to benefits, an insured's agreement to release the insurer in exchange for a settlement, does not release the insurer as to the provider's noticed claims unless the insurer complies with MCL 500.3112." (*Id.*).

ARGUMENT

I. STANDARD OF REVIEW

Whether to grant leave to appeal is within this Court's discretion. Should the Court grant leave, this Court reviews *de novo* a trial court's decision on a motion for summary disposition under MCR 2.116(C)(7). *See, e.g., DiPonio Constr Co, Inc v Rosati Masonry Co, Inc*, 246 Mich App 43, 46; 631 NW2d 59 (2001). This Court also reviews *de novo* underlying issues of statutory interpretation. *See, e.g., Stanton v City of Battle Creek,* 466 Mich 611, 614; 647 NW2d 508 (2002).

II. THE COURT OF APPEALS' DECISION INVOLVES LEGAL PRINCIPLES OF MAJOR SIGNIFICANCE TO THE STATE'S JURISPRUDENCE

As stated in the Introduction, the Court of Appeals' decision has rocked the no-fault world. By way of brief explanation, injured parties, providers, and the Circuit Courts, have interpreted the No-Fault Act to mean that one motor vehicle accident involving one injured person's claim for benefits can give rise to multiple lawsuits in different jurisdictions against a single insurer. An injured party may sue in Wayne County Circuit Court, one of his providers may sue in 35th District Court, and yet another provider may sue in Oakland County Circuit Court. [2] As but one example, one auto accident with two injured persons gave rise to seven

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Covenant's claim before settling with Mr. Stockford, presumably it was because Covenant had sent medical bills to State Farm.

[2] This is not alarmist, the prevalence of no-fault suits on the same claim in different courts is very real. There is currently a case before this Court regarding the jurisdiction of the district

lawsuits against State Farm in four different courts.[3] All of the suits involve the same accident and all involve the same question, namely, whether and what the insurer is liable to pay under the No-Fault Act. Under the Court of Appeals' decision, the insurer is required to ask the Circuit Court to make a benefit apportionment before it can pay benefits, but which Circuit Court conducts the apportionment proceeding and does it have jurisdiction to essentially decide a claim (or claims) pending in another court?

In addition, under the Court of Appeals' ruling, an insurer seeking a complete discharge of a claim will be required to seek an apportionment order from a Circuit Court even if no litigation is pending. Seemingly, the insurer will be required to bring an action in order to create a case in which to seek an apportionment order. And in cases in which litigation was already pending, the apportionment order will be required on amounts regardless of how they were reached – by settlement, acceptance of case evaluation awards, facilitation, arbitration, or jury verdict. Alternative dispute resolution and mandatory case evaluation – designed precisely to resolve cases expeditiously – will no longer serve their purpose in no-fault cases as court involvement will still be necessary.

Another question raised by the Court of Appeals' opinion is what constitutes "notif [ication] in writing of the claim of some other person"? If an interrogatory answer by an insured

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courts over no-fault cases and how claimants often chose to reduce their potential recovery in order to be in District Courts rather than Circuit Courts due to a perceived better chance of recovery in the former. *Hodge v State Farm Mut Auto Ins Co*, 304 Mich App 415; 849 NW2d 31 (2014) (appeal currently pending before this Court).

[3] *Russell and Young v State Farm Mut Auto Ins Co,* Wayne Co Cir Ct Case No 11-009075; *Russell and Young v State Farm Mut Auto Ins Co*, Wayne Co Cir Ct Case No 11-010633; *Maple Millennium Med Ctr, PLLC v State Farm Mut Auto Ins Co*, 46th Dist Ct Case No. 11-3761; *Maple Millennium Med Ctr, PLLC v State Farm Mut Auto Ins Co*, 46th Dist Ct Case No 11-3744; *Summit Medical Group, PLLC v State Farm Mut Auto Ins Co*, 50th Dist Ct Case No 12-157483; *Summit Medical Group, PLLC v State Farm Mut Auto Ins Co*, Wayne Co Cir Ct Case No 12-008722; *Doughty PC v State Farm Mut Auto Ins Co*, 31st Dist Ct Case No 12-51424.

indicates he treated with Dr. Doe but Dr. Doe did not send any medical bills to the insurer, does the insurer need to bring Dr. Doe into an apportionment proceeding in the Circuit Court because it has been put "on notice" of a claim? What about a written note that the insured's sister has helped out with housework; is that "notice" of a claim by the sister for replacement services and does she too need to be included in an apportionment proceeding? The possibilities are endless and the now-required apportionment proceedings may well become three-ring circuses. The lower courts will be overwhelmed by no-fault cases and proceedings, and legal costs will increase, which is exactly what the No-Fault Act was designed to remedy.

Furthermore, payments will inevitably be delayed; insurers will now be hesitant to pay benefits unless and until a circuit court issues an apportionment order, or the insurer is otherwise confident that the insured can bind his or her providers and the settlement truly will be a "release" of all PIP claims. In either event, resolution of claims will take much longer, contrary to the goals of the No-Fault Act.

Finally, this case clearly involves the rights and liabilities of insurers, insureds, and health care providers. Who is entitled to seek payment of PIP benefits is a fundamental question under the No-Fault Act. The same is true of the question to whom insurers may be liable for payment of benefits.

Because the Court of Appeals decision involves legal principles of major significance to the State's jurisprudence, leave to appeal is warranted under MCR 7.305(B)(3).

III. THE COURT OF APPEALS' DECISION IS CLEARLY ERRONOUS AND WILL CAUSE MATERIAL INJUSTICE.

A. The Court of Appeals Incorrectly Interpreted the Statutory Language.

When interpreting statutes, courts must "determine and effectuate the intent of the Legislature through reasonable construction in consideration of the purpose of the statute and the

object sought to be accomplished." *Frankenmuth Mut Ins Co v Marlette Homes*, 456 Mich 511, 515; 573 NW2d 611 (1998). The Court of Appeals erroneously read Section 3112 to essentially require no-fault insurers to apply to the Circuit Court for an apportionment order every time it receives any written correspondence, bill, or other "notice" from a medical provider or any other "person" before it makes a payment to the insured. This interpretation is clearly erroneous.

Section 3112 provides one way for an insurer to discharge a liability—through the process provided for in that statute—but it is certainly not the only way to do so. The plain language of the statute and common sense and practice make this clear and establish the Court of Appeals erred.

"Where a statute is clear and unambiguous, judicial construction is precluded. If judicial interpretation is necessary, the Legislature's intent must be gathered from the language used, and the language must be given its ordinary meaning. In determining legislative intent, statutory language is given the reasonable construction that best accomplishes the purpose of the statute." *Frankenmuth Mut Ins Co,* 456 Mich at 515.

Thus, the analysis begins with the plain language of the statute. *Ameritech Mich v PSC (In re MCI)*, 460 Mich 396, 411; 596 NW2d 164 (1999). Section 3112 states, in its entirety:

> Personal protection insurance benefits are payable to or for the benefit of an injured person or, in case of his death, to or for the benefit of his dependents. Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person. If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person may apply to the circuit court for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and

> other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay:
>
> (a) To the dependents of the injured person, the personal protection insurance benefits accrued before his death without appointment of an administrator or executor.
>
> (b) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse.

The Court of Appeals interpreted this provision to mean that "if the insurer has notice in writing of a third party's claim, then the insurer **cannot** discharge its liability to the third party simply by settling with its insured." (Exhibit A, p. 2) (emphasis added). According to the Court of Appeals, "[s]uch a payment is not in good faith because the insurer is aware of a third party's right and seeks to extinguish it without providing notice to the affected party. Instead, the statute **requires** that the insurer apply to the circuit court for an appropriate order directing how the no-fault benefits should be allocated." (*Id.*, pp. 2-3) (emphasis added). The Court of Appeals' interpretation of Section 3112 is incorrect.

1. A statutory discharge is not the only way to discharge an insurer's liability even if the insurer has "notice" of a third party's claim.

Despite the Court of Appeals' seemingly straightforward statements about Section 3112, the plain language of the statute does not provide that the **only** way an insurer may discharge its liability to pay PIP benefits is through Section 3112, even if it receives "notice"[4] of a third party's claim. As this Court has previously recognized, Section 3112 provides a "'safe' method"

[4] As discussed below, the Court of Appeals did not directly address the concept of what constitutes "notification in writing", but implicitly found that Covenant's medical bills sent to State Farm constituted notice for purposes of Section 3112. If not reversed, the Court of Appeals' decision could be read to mean that anytime an insurer receives any piece of paper (or electronic correspondence) that identifies the injured person and provides information that indicates a third party believes it is owed some payment by the injured person for covered services, the insurer could not settle with the injured person, but would need to round up every potential "claimant" and apply to the Circuit Court for an apportionment order. This result is absurd and completely defeats the purpose of the No-Fault Act.

of payment. *Miller,* 410 Mich at 568. In other words, Section 3112 provides how an insurer may *statutorily* discharge its liability to pay PIP benefits—by making a good faith payment to a person who it believes is entitled to the benefits so long as the insurer has not been notified in writing of the claim of some other person. The statute does not state that it is the **only** way by which an insurer may discharge its liabilities, but rather provides **one** safe way by which an insurer can do so, even if it ultimately makes a payment to the wrong person.

> Payment by an insurer **in good faith** of personal protection insurance benefits, to or for the benefit of a person **who it believes** is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person.

MCL 500.3112 (emphasis added).

For example, if an injured person succumbs to his or her injuries and an insurer makes payments to Dependent X, who the insurer believes is entitled to the benefits, and then Dependent Y comes forward to claim benefits, the insurer has no liability to Dependent Y to the extent of the payments made to Dependent X, regardless of whether Dependent X was actually entitled to the benefits. However, if Dependent Y had notified the insurer in writing of its claim before the insurer made the payment to Dependent X, the insurer could not argue that its liability was statutorily discharged. (And in this second scenario, Section 3112 does not provide that the insurer could not defend against a claim by Dependent Y in court that it had no liability to pay Dependent Y, it just could not rely on Section 3112 to claim its liability was discharged.)

The fact that Section 3112 does not preclude discharge through settlements or releases, regardless of third party claims, comports with this Court's recognition that the ability to settle no-fault cases is "essential" to meeting the goals of the No-Fault Act. *USF&G*, 484 Mich at 25. If a Section 3112 apportionment order is the only way that an insurer can discharge its liabilities, settlements will become much more costly and time-consuming.

Moreover, as the Circuit Court correctly held, case law provides that executing a broad release, like the Release in this case, discharges an insurer's liability. *Michigan Head & Spine* held that an insurer's liability may be discharged via a release with the injured person and such a release operates as a bar to a provider's claim for benefits under Section 3112. The court held:

> This Court has recognized that the language in MCL 500.3112 "specifically contemplates the payment of benefits to someone other than the injured person . . . ." *Lakeland Neurocare Ctrs v State Farm Mut Auto Ins Co*, 250 Mich App 35, 39; 645 NW2d 59 (2002). "As a result, it is common practice for insurers to directly reimburse health care providers for services rendered to their insureds." *Id.* **It is well established that an injured person entitled to no-fault benefits may waive that entitlement and release an insurer from payment of future benefits in exchange for a settlement.** *Lewis v Aetna Casualty & Surety Co*, 109 Mich App 136, 140; 311 NW2d 317 (1981). The issue presented in this case is whether an insured's release bars a healthcare provider's claim for payment for medical services rendered to the insured after the release was executed.

299 Mich App at 447-48 (emphasis added).

The Court of Appeals then determined that, based on ordinary contract principles, "the plain language [of the release] demonstrates that, in exchange for defendant's payment of $35,000, the parties intended to discharge defendant's liability altogether, including its liability for future medical services. The language of the release is clear and unambiguous, and the parties' intent, expressed in the release, governs its scope." *Id.* at 448-49. In this case, much like the release in *Michigan Head & Spine*, Mr. Stockford and State Farm entered into a very clear and unambiguous release under which, in exchange for State Farm's payment of $59,000, the parties intended to discharge State Farm's liability altogether. Indeed, it is difficult to imagine clearer language on this point than that contained in the Release.

> It is understood and agreed that this full and final release is a complete release of [State Farm] regarding any and all past and present claims incurred through January 10, 2013, under the Michigan No-Fault Act the undersigned may have under the

> Michigan Automobile No-Fault Act, including but not limited to allowable expenses, medical bills, attendant care, medical mileage, work loss, replacement services, attorney fees, interest and costs arising from the June 20, 2011 accident alleged in the complaint.
>
> ....
>
> The parties agree that the settlement payment referenced above is given as compensation in full satisfaction for any and all claims for no-fault benefits incurred through January 10, 2013, and for past, present and future wage loss claims under the Michigan Automobile No-Fault Act, and including but not limited to, attorney fees, costs and expenses.

(Exhibit D, pp.1, 3.)

The Court of Appeals in this case distinguished *Michigan Head & Spine* on the grounds that the issue there was whether the insured's release barred a healthcare provider's claim made *after* the release was executed, as opposed to here where Covenant sent bills to State Farm *before* the Release was executed. (Exhibit A, p. 3.) This factual difference, however, is irrelevant. As the Circuit Court correctly pointed out, written notice under Section 3112 "is only relevant to determining whether an insurer is *statutorily* discharged of liability under Section 3112 to the extent that it paid a claim for benefits in good faith." (Exhibit B, p. 5, emphasis added.) The insurer's liability in *Michigan Head & Spine* – and in the instant case – was terminated by the release, not by the statute. *Michigan Head & Spine* expressly acknowledged that an injured person is entitled to waive his or her entitlement to benefits and release an insurer for liability for same in exchange for a settlement. The court therefore held that a settlement and release covering existing and future claims for benefits was enforceable against a medical provider seeking to obtain payment on behalf of the insured. In other words, the second sentence of Section 3112 is irrelevant when a release is involved. Whether the case involves future medical bills (like in *Michigan Head & Spine*) or disputed past bills (like here), if the injured person

executes a release that releases the insurer of liability for such claims, that release is dispositive as to the insurer's liability.[5]

At least two other cases also buttress this conclusion. *Moody* and *Miller v Citizens Ins Co,* 490 Mich 904; 804 NW2d 740 (2011). In *Moody*, the Court of Appeals found that an injured person "may waive by agreement his or her claim against an insurer for no-fault benefits, and a service provider is bound by the waiver." 304 Mich App at 443. In *Miller*, the injured person and insurer entered into a settlement agreement that included the costs of medical treatments. Although in that case the primary issue was whether a provider, who did not bring its own claim for benefits, was liable for attorneys fees to the insured person's attorney, this Court made clear that in the event of such a settlement, a provider still had recourse against the injured person. "The circuit court's order of dismissal pursuant to the settlement agreement did not have the effect of extinguishing the [provider's] right to collect the remainder of its bill from plaintiff." 490 Mich at 904.

To reiterate, Section 3112 provides an insurer with a "safe" method by which it may make payments, but is not the only way by which liabilities may be discharged. Discharge by release has been long acknowledged by Michigan courts as one permissible route by which an insurer may discharge its liabilities – an integral route at that – and Section 3112 should have no effect on that method. Section 3112 simply states that if an insurer makes a payment in good faith to a person the insurer believes is entitled to such payment, the insurer's liability is discharged to the extent of that payment. If, however, the insurer is notified in writing of the claim of some other person before it makes a good faith payment, the statute does not provide automatic protection for the insurer. It does not mean that the liability cannot otherwise be

[5] As this Court has recognized in *Miller v Citizens Ins Co,* 490 Mich 904; 804 NW2d 740 (2011), it is not dispositive of the injured person's liability to the provider, as discussed next.

discharged (by release, for example), it just means that it is not statutorily discharged. Once Mr. Stockford released State Farm for all claims incurred through January 10, 2013, State Farm was no longer liable to make payments for such claims, including the claims of Covenant. If a third party, such as Covenant, believes it is entitled to payment after such a release is executed, that party must seek such payment from the injured person.

2. Section 3112 does not mandate applying to the Circuit Court even if there is a dispute over the proper person to receive payment.

Even if one could read Section 3112 to mean that an insurer cannot discharge its liabilities without a court order once it receives notice from a provider (which is not consistent with the statute's plain language), it still does not **mandate** that the insurer apply to the Circuit Court to resolve a dispute, as the Court of Appeals held. Section 3112 states:

> If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person **may apply to the circuit court** for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay:
>
> (a) To the dependents of the injured person, the personal protection insurance benefits accrued before his death without appointment of an administrator or executor.
>
> (b) To the surviving spouse, the personal protection insurance benefits due any dependent children.

(Emphasis added).

It is well established that "the term 'may' is permissive,'... as opposed to the term 'shall,' which is considered 'mandatory.'" *See, e.g., Manuel v Gill*, 481 Mich 637, 647; 753 NW2d 48 (2008). Thus, even if Section 3112 applied to this set of circumstances, the plain language of the statute does not "require" an insurer to apply to the Circuit Court, as the Court of Appeals

incorrectly held. (Exhibit A, p. 2.) Indeed, the last sentence of the statute even acknowledges that it is acceptable for there to be an absence of a court order. The fact that the Circuit Court process is not mandatory makes sense given the goals of the No-Fault Act (*i.e.,* lower legal costs, decreased burden on judicial system, and prompt payment) as well as the fact that, as discussed above, Section 3112 does not provide the only way in which liabilities may be discharged but simply provides a "safe method" by which insurers may proceed if they receive notice from some other person.[6]

3. A provider claim is not a "claim of some other person".

Again, even if one assumes that Section 3112 is the only route by which an insurer may discharge its liability with respect to PIP benefits (which is not accurate), State Farm could have statutorily discharged its liability for claims regarding Mr. Stockford by paying the settlement amount so long as it did not receive notification in writing of a claim of "some other person." While on its face, it may seem that a claim of "some other person" could mean any third party, including a provider, such an interpretation would be contrary to the plain language of Section 3112 and applicable precedent.

Under Section 3112's plain language, PIP benefits are payable either (1) to injured persons **OR** (2) for the benefit of an injured person. The statute reads in the disjunctive ("or")—meaning a choice between alternatives. *Jesperson v Auto Club Ins Ass'n*, 306 Mich App 632, 643; 858 NW2d 105 (2014) ("The word 'or' is a disjunctive term indicating a choice between alternatives."). The Court of Appeals in *Chiropractors Rehabilitation Group, PC v State Farm*

[6] The statute also provides that a claimant or "any other interested person" may apply to the Circuit Court for an order apportioning benefits. MCL 500.3112. If a Section 3112 apportionment order is truly the only route by which an insurer may discharge a liability when there are multiple "claimants," as discussed above, insurers will be running to Circuit Courts in droves to be sure that they can discharge their liabilities, and potentially other claimants may also be seeking such orders.

Mut Auto Ins Co, __ Mich App ___; __ NW2d ___(2015), recently made this exact point.[7] In other words, a PIP benefit need only be paid once, either to the injured person **or** for the benefit of the injured person – not both. This aligns with the precedent that PIP benefits ultimately belong to the injured person. *Hatcher v State Farm Mut Auto Ins Co*, 269 Mich App 596, 600; 712 NW2d 744 (2005) ("the right to bring an action for personal protection insurance benefits, including claims for attendant care services, belongs to the injured party"); *In re Hales Estate*, 182 Mich App 55, 58; 451 NW2d 867 (1990) ("benefits payable under the no-fault act belong to the injured person"). Thus, if both a provider and an injured person seek payment for the same claim, the payment should go to the injured person, not the provider.[8]

Stated simply, Section 3112 provides that "payment by an insurer in good faith of personal protection insurance benefits **to or for the benefit of a person who it believes is entitled to the benefits** discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of **some other person**." MCL 500.3112 (emphasis added). When an insurer makes payment to an injured party, that is the person who is entitled to the benefit. A provider claim is not a "claim of another person"; it is, instead, a claim of the injured party. The second sentence of Section 3112 really speaks to survivor's loss benefits, which is why the claim of "some other person" does not make sense in the context of the instant case. The phrase "to or for the benefit of a person who [the insurer] believes is entitled to the benefits" helps clarify its meaning. Since the PIP benefits belong to the injured person the injured person is the only person to or for whom the allowable expenses are payable.

[7] Although State Farm agrees with the Court of Appeals' interpretation of the plain language of Section 3112's use of the disjunctive "or" in *Chiropractors Rehabilitation,* State Farm does not agree with the Court of Appeals' entire analysis in that case.

[8] Again this does not mean that a provider is left without recourse; it can seek recovery from the insured who received payment precisely for PIP benefits. See *Miller*, 490 Mich at 904.

There is therefore no doubt as to the proper person to receive such benefits. Such doubt only arises if there is a survivor's loss claimant presumed to be a dependent under MCL 500.3110(1). The fact that the remaining sentences in Section 3112 speak to survivor's losses buttresses this conclusion.

In fact, many Michigan courts have recognized that provider's claims are derivative of the injured person's claims. *Bahri v IDS Property Cas Ins Co*, 308 Mich App 420, 424; 864 NW2d 609 (2014) (provider "stood in the shoes of the named insured, if [the insured] cannot recover benefits, neither can [the provider]"); *TBCI, PC v State Farm Mut Auto Ins Co*, 289 Mich App 39, 44; 795 NW2d 229 (2010) (provider was "essentially standing in the shoes" of the insured). And, relatedly, a provider's eligibility is completely dependent upon the injured person's eligibility. *Bahri*, *supra* at 424. The Court of Appeals recently articulated this in *Moody*:

> While the providers may bring an independent cause of action against a no-fault insurer, **the providers' claims against Home Owners are completely derivative of and dependent on Moody's having a valid claim of no-fault benefits against Home Owners**. Specifically, the providers' claims are dependent on establishing Moody's claim that he suffered "accidental bodily injury arising out of the...use of a motor vehicle," MCL 500.3105(1), that they provided "reasonably necessary products, services and accommodations for [Moody's] care, recovery, or rehabilitation," MCL 500.3107(1)(a), and that at the time of the accident, Moody was "domiciled in the same household" as his father who was insured by Home Owners, MCL 500.3114(1). **The providers' and Moody's claims with respect to the requisites of Home Owners' liability are therefore identical.** Because there is an identity between Moody's claims and those of the providers and because the claims were consolidated for trial, we consider them merged for the purpose of determining the amount in controversy under MCL 600.8301(1).

304 Mich App at 440-41 (emphasis added). Similarly, if an injured person cannot recover a claim because the service was not reasonably necessary, then neither can the provider. If an

injured person cannot recover a claim because he committed fraud in connection with his claims, and the policy is voided, then neither can the provider. The same logic should hold when it comes to releases – if an injured person cannot recover a claim because he signed a release, then neither can the provider.

Although the Court of Appeals acknowledged *Moody* and the fact that the source of a provider's right to PIP benefits is based on the insured's right, it then found that because other Michigan cases state that a provider has "independent standing" to bring a claim, an injured person cannot release the insurer from liability through a settlement unless the insurer complies with Section 3112. (Exhibit A, p. 3.) This conclusion is legally inconsistent. The premise that a provider may have standing to sue[9] does not mean its cause of action is independent from the injured party's claim. The Court of Appeals' decision here is the first case to find that a provider's claim is one of "some other person" that is independent of the claim of the injured person. (A fact that is directly at odds with the Court of Appeals' explicit acknowledgment that the source of the provider's right is the injured person's right to recover benefits. (Exhibit A, p. 3.)) Indeed, when a provider submits its bills to an insurer, it does so "for the benefit of the injured person", as that is the only way under Section 3112 anyone other than the injured person is able to receive payment of benefits. Any right that a provider has, if one exists, is entirely dependent upon and tied to the injured person. In short, the claim of a provider is not the claim of an "other person" that would preclude statutory discharge.

B. <u>The Court of Appeals Decision is Contrary to the Goals of the No-Fault Act.</u>

As stated extensively above, the Court of Appeals' decision, unless reversed, will cause

[9] State Farm does not agree that providers have a statutory right to bring their own causes of action against insurers for PIP benefits, but assume only for the sake of argument here that they do.

litigation to exponentially increase, defeat the purpose of alternative dispute resolution, make settlement much more difficult, increase costs for all involved, and delay the payment of claims. It is completely contrary to the Legislative intent behind the No-Fault Act and is a giant step backwards in No-Fault law.

For all of these reasons, the Court of Appeals' opinion is clearly erroneous and will cause material injustice. Leave to appeal should be granted under MCR 7.305(B)(5).

IV. THE COURT OF APPEALS' DECISION CONFLICTS WITH OTHER DECISIONS OF THE COURT OF APPEALS

The Court of Appeals' decision conflicts with not only the plain language of the statute, but also with other Court of Appeals decisions. As discussed above, several published Court of Appeals' decisions hold that a provider's right to payments of PIP benefits is derivative of the injured person's right and the provider "stands in the shoes" of the injured person. *See Bahri; TBCI, Moody. Moody* articulated this perfectly:

> While the providers may bring an independent cause of action against a no-fault insurer, **the providers' claims against Home Owners are completely derivative of and dependent on Moody's having a valid claim of no-fault benefits against Home Owners....The providers' and Moody's claims with respect to the requisites of Home Owners' liability are therefore identical.** Because there is an identity between Moody's claims and those of the providers and because the claims were consolidated for trial, we consider them merged for the purpose of determining the amount in controversy under MCL 600.8301(1).

304 Mich App at 440-41 (emphasis added).

The Court of Appeals' decision in this case, however, stated that:

> *Moody* made it clear that the source of a provider's right to no-fault benefits is based on the insured's right to benefits. However, it is also well-settled that a medical provider has independent standing to bring a claim against an insurer for the payment of no-fault benefits....And, while a provider's right to payment from the insurer is created by the right of the insured to benefits, an insured's agreement to release the insurer in exchange for a

> settlement, does not release the insurer as to the provider's noticed claims unless the insurer complies with MCL 500.3112.

(Exhibit A, p. 3.) (internal citations omitted). *Moody* not only stated that the source of a provider's right to PIP benefits is based on the injured person (which comports with the plain language of Section 3112),[10] but that a provider's claim is "**completely derivative**" of, and "**identical" to**, the injured person's claim. 304 Mich App at 440-41 (emphasis added). The Court of Appeals also held in *Michigan Head & Spine* that an injured person may release an insurer from liability and that a provider's right to seek benefits from the insurer, if any, is thereby also extinguished (but the provider's right to seek payment from the injured person is not extinguished, so they are not without a remedy).[11]

The Court of Appeals' decision is directly at odds with these cases. Under the Court of Appeals' decision, a provider's right to receive payment is essentially **completely independent of,** and **separate from**, the injured person's right to receive payment.[12] In short, before the Court

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[10] As discussed above, payment of PIP benefits must either go to: (1) the injured person, OR (2) for the benefit of the injured person. MCL 500.3112.

[11] That, following a settlement with the insurer, providers should seek payment from the injured person only makes sense. PIP benefits are not for an injured person to pocket, rather, they are to be paid by the injured person to the persons or entities that provided reasonable and necessary services to him or her as a result of the accident.

[12] The Court of Appeals' reliance on *Lakeland Neurocare Centers v State Farm Mut Auto Ins Co*, 250 Mich App 35; 645 NW2d 59 (2002) and *Wyoming Chiropractic Health Clinic PC v Auto Owners Ins Co*, 308 Mich App 389; 864 NW2d 598 (2014), for the premise that a medical provider has an independent right to payment, is misplaced. The concept of such a right appears to have originated in *Lakeland*, in which the provider, not the injured person, brought the lawsuit, and no release existed. The Court of Appeals there also specifically acknowledged that the right of the medical provider to bring the claim at all had not been challenged on appeal. 250 Mich App. at 37. *Lakeland* actually involved penalty interest and attorneys' fees, not a medical provider's right to bring a claim. Despite the fact that the issue of a medical provider's right to bring a claim was not before the *Lakeland* court, subsequent courts, including *Wyoming Chiropractic*, have erroneously attributed such an conclusion to *Lakeland* and treated *Lakeland* as conclusive evidence of a provider's right. But again, for purposes of this Application, whether or not there is such a right is not the main focus; even if providers have this right, it does not

of Appeals' decision in this case, there was no case that granted providers rights separate and independent of an injured person, but now there is binding precedent to that effect. But a provider's right (if any exists), must necessarily be tied to the injured person since without the injured person, there are no PIP benefits to be paid.

The Court of Appeals' decision conflicts with other decisions of the Court of Appeals, and leave should be granted under MCR 7.305(B)(5).

CONCLUSION AND REQUEST FOR RELIEF

For the above stated reasons, Defendant-Appellant respectfully requests that this Court grant its Application for Leave to Appeal and on appeal, reverse the Court of Appeals' opinion and reinstate the Circuit Court opinion and order.

Respectfully submitted,

DYKEMA GOSSETT PLLC

Dated: December 3, 2015

By: */s/ Jill M. Wheaton*

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stand alone and is affected by, and can therefore be barred by, the actions of the injured person. In addition, the issues raised in this case persist even if the provider has not brought its own suit, as the Court of Appeals decision applies to any settlement where the insurer has received notice of a claim of "some other person", not just where that "other person" has brought suit.

INDEX TO EXHIBITS

A. Court of Appeals Oct 22, 2015 Opinion

B. Saginaw County Circuit Court May 15, 2015 Opinion and Order

C. Complaint

D. Release signed by Jack Stockford

CERTIFICATE OF SERVICE

On December 3, 2015 I e-filed this Application For Leave To Appeal with the Michigan Supreme Court and served a copy of this Application upon:

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by enclosing copies of the same in envelopes properly addressed, and by depositing said envelopes in the United States Mail with postage thereon having been fully prepaid.

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